IN THE COURT OF APPEALS OF THE
STATE OF OREGON

PROVIDENCE HEALTH PLAN,
as claims administrator for
the Oregon Employees Benefit Board,
Plaintiff-Appellant,

v.

Joe Lewis ALLEN,
Defendant-Respondent.

Washington County Circuit Court
C143957CV; A160124

Andrew Erwin, Judge.

Argued and submitted February 28, 2017.

Sharon A. Rudnick argued the cause for appellant. Also on the briefs were Arden J. Olson and Harrang Long Gary Rudnick P.C.

Thomas H. Anderson argued the cause for respondent. Also on the brief was Thomas H. Anderson, P.C.

Before Ortega, Presiding Judge, and Lagesen, Judge, and Powers, Judge.*

ORTEGA, P. J.

Affirmed.

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* Powers, J., *vice* Garrett, J. pro tempore.

ORTEGA, P. J.

Plaintiff, Providence Health Plan (Providence), sought subrogation from defendant, a participant in one of the Oregon Public Employees Benefits Board's (PEBB's) self-insured health plans (the plan), for medical benefits paid on defendant's behalf after defendant was involved in a car accident. Defendant asserted that reimbursement was governed by statute rather than by the terms of the plan. The trial court agreed with defendant, finding that PEBB and Providence are insurers required to follow the requirements of the reimbursement statutes and granting summary judgment to defendant. On appeal, Providence challenges that ruling and the denial of its own motion for summary judgment, arguing that neither PEBB nor Providence is an insurer and that neither is subject to the reimbursement statutes. Because we conclude that Providence is deemed an insurer and required to follow the requirements of the reimbursement statutes, we affirm.

The following facts are undisputed.[1] In May 2012, defendant was injured in a motor vehicle accident due to the negligence of another driver. At the time of the accident, defendant was a participant in the plan. PEBB contracted with Providence to act as the plan's third-party administrator. As third-party administrator, Providence processed claims, provided customer service to participants, and developed and managed panels of providers in the plan's network. In accordance with the plan, Providence paid $56,536.36 in medical expenses related to defendant's injuries.

A provision of the plan, the third-party liability and subrogation provision, required defendant to reimburse PEBB from any judgment, settlement, or other monetary recovery for amounts paid for medical expenses related to injuries inflicted by a third party. Providence, as third-party administrator, was authorized to enforce the plan by initiating litigation in its name to obtain that reimbursement on PEBB's behalf. Under the plan, PEBB was also entitled

[1] All statutory references in this opinion are to the 2011 version of the statutes. Many of the statutes referenced have been amended numerous times since 2011, but those amendments do not affect our analysis.

to offset future benefits otherwise payable under the plan to the extent of the benefits advanced but not repaid from a third-party settlement or judgment. The plan also provided that, after a participant received proceeds of a settlement from a third party, the participant would be responsible for payment of all medical expenses for continuing treatment from the injury that the plan would otherwise be required to pay, until all proceeds from the settlement or recovery were exhausted.

The other driver had an auto liability insurance policy with Nationwide Insurance with a policy limit of $50,000. In at least five letters to Nationwide, Providence sought direct interinsurer reimbursement for the medical expenses it paid on defendant's behalf, asserting its reimbursement rights under ORS 742.534.[2] After Nationwide informed Providence that it was paying policy limits directly to defendant, but before defendant settled with Nationwide, Providence asserted its subrogation rights against defendant

[2] ORS 742.534 provides:

"(1) Except as provided in ORS 742.544, every authorized motor vehicle liability insurer whose insured is or would be held legally liable for damages for injuries sustained in a motor vehicle accident by a person for whom personal injury protection benefits have been furnished by another such insurer, or for whom benefits have been furnished by an authorized health insurer, shall reimburse such other insurer for the benefits it has so furnished if it has requested such reimbursement, has not given notice as provided in ORS 742.536 that it elects recovery by lien in accordance with that section and is entitled to reimbursement under this section by the terms of its policy. Reimbursement under this subsection, together with the amount paid to injured persons by the liability insurer, shall not exceed the limits of the policy issued by the insurer.

"(2) In calculating such reimbursement, the amount of benefits so furnished shall be diminished in proportion to the amount of negligence attributable to the person for whom benefits have been so furnished, and the reimbursement shall not exceed the amount of damages legally recoverable by the person.

"(3) Disputes between insurers as to such issues of liability and the amount of reimbursement required by this section shall be decided by arbitration.

"(4) Findings and awards made in such an arbitration proceeding are not admissible in any action at law or suit in equity.

"(5) If an insurer does not request reimbursement under this section for recovery of personal injury protection payments, then the insurer may only recover personal injury protection payments under the provisions of ORS 742.536 or 742.538."

under ORS 742.538.[3] Defendant recovered a $100,000 settlement, $50,000 from Nationwide and $50,000 from his own underinsured motorist (UIM) coverage.

Providence, on PEBB's behalf, filed this action against defendant for breach of contract under the plan's third-party liability and subrogation provision, alleging that defendant is required under the plan to reimburse PEBB from his settlement money for amounts that the

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[3] ORS 742.538 provides:

"If a motor vehicle liability insurer has furnished personal injury protection benefits, or a health insurer has furnished benefits, for a person injured in a motor vehicle accident, and the interinsurer reimbursement benefit of ORS 742.534 is not available under the terms of that section, and the insurer has not elected recovery by lien as provided in ORS 742.536, and is entitled by the terms of its policy to the benefit of this section:

"(1) The insurer is entitled to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of the injured person against any person legally responsible for the accident, to the extent of such benefits furnished by the insurer less the insurer's share of expenses, costs and attorney fees incurred by the injured person in connection with such recovery.

"(2) The injured person shall hold in trust for the benefit of the insurer all such rights of recovery which the injured person has, but only to the extent of such benefits furnished.

"(3) The injured person shall do whatever is proper to secure, and shall do nothing after loss to prejudice, such rights.

"(4) If requested in writing by the insurer, the injured person shall take, through any representative not in conflict in interest with the injured person designated by the insurer, such action as may be necessary or appropriate to recover such benefits furnished as damages from such responsible person, such action to be taken in the name of the injured person, but only to the extent of the benefits furnished by the insurer. In the event of a recovery, the insurer shall also be reimbursed out of such recovery for the injured person's share of expenses, costs and attorney fees incurred by the insurer in connection with the recovery.

"(5) In calculating respective shares of expenses, costs and attorney fees under this section, the basis of allocation shall be the respective proportions borne to the total recovery by:

"(a) Such benefits furnished by the insurer; and

"(b) The total recovery less (a).

"(6) The injured person shall execute and deliver to the insurer such instruments and papers as may be appropriate to secure the rights and obligations of the insurer and the injured person as established by this section.

"(7) Any provisions in a motor vehicle liability insurance policy or health insurance policy giving rights to the insurer relating to subrogation or the subject matter of this section shall be construed and applied in accordance with the provisions of this section."

plan paid for defendant's medical expenses. Providence also denied defendant's additional claims for payment of medical expenses for continuing treatment for his injuries. Defendant responded, in an affirmative defense, that PEBB's right to reimbursement was governed exclusively by the terms of ORS 742.534 to 742.538 (the reimbursement statutes) rather than by the plan's subrogation provision and that Providence's failure to comply with those statutes barred its breach of contract claim. Defendant also counterclaimed for a judgment against Providence in the amount of the medical claims that Providence had denied. The parties filed cross-motions for partial summary judgment on the issue of whether Providence's breach of contract claim was barred by the reimbursement statutes.

In its motion, Providence argued that PEBB is not an "authorized health insurer" as that term is used in the reimbursement statutes. Because PEBB is a self-insured labor-management board governed by the provisions of ORS 243.061 to 243.350, Providence asserted that neither the reimbursement statutes nor the Insurance Code apply to PEBB. Providence also argued that, as third-party administrator for the plan, Providence is not acting on its own behalf as an insurer and, thus, is not subject to the reimbursement statutes. Defendant argued, in his motion, that Providence is deemed an insurer, whether it acts as a health insurer, health care service contractor, or a third-party administrator; that its claims for subrogation and breach of contract are controlled exclusively by the reimbursement statutes; and that, under those statutes, Providence is not entitled to reimbursement.

The trial court agreed with defendant and granted summary judgment in his favor, reasoning that PEBB and, by association, Providence are considered insurers for the purpose of the reimbursement statutes and, accordingly, are subject to the requirements of those statutes. The court explained:

> "[B]oth [parties] agree that <u>if</u> PEBB is deemed an 'authorized health insurer' then plaintiff was required to follow the reimbursement requirements of ORS 742.534 et. seq., which they concede they did not. And both parties agree

> that if Providence was acting in its capacity as a 'health care service contractor' plaintiff was again required to follow the same statute.
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> "Plaintiff argues that PEBB is exempt from the insurance code, but can offer no reason why it fails to qualify for exemption status under ORS 731.036 [listing persons exempt from the insurance code]. Plaintiff argues that PEBB is a managed self-insurance program and therefore is not an 'insurer' for the purposes of ORS 742.534. But plaintiff concedes that if any other insurance provider were providing the same insurance benefits as PEBB they would be defined as an insurer. Accordingly, I find that PEBB, and by association, Providence are 'insurer's' [*sic*] for the purpose of ORS 742.534.
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> "As insurers, they are authorized by statute to provide coverage benefits and are subject to the reimbursement requirements of ORS 742.534 et. seq. Providence expressly acknowledged that they, and PEBB, were subject to this statutory scheme in six separate letters to the third party insurers in this case. Accordingly, Defendant's Motion for Partial Summary Judgment is granted, and Plaintiff's Motion for Partial Summary Judgment is denied."

(Underscoring in original; footnotes omitted.) The trial court also noted:

> "This is consistent with the Supreme Court's analysis of what constitutes an 'insurer' under the insurance code in *Haynes v. Tri-County Metro.*, 337 Or 659[, 103 P3d 101] (2004) (holding that even an exempt public self-insurer is deemed to be an insurer under specific provisions of the insurance code if their coverage plans are identical to contemplated plans under the code)."

Defendant filed a second motion for partial summary judgment on the issue of whether Providence was required to pay defendant's claims for ongoing medical expenses that Providence had denied under the plan. The trial court granted defendant's motion.

On appeal, Providence raises four assignments of error. In its first assignment of error, Providence challenges the trial court's decision granting defendant's motion for partial summary judgment on defendant's second affirmative defense, and in its second assignment of error, Providence

challenges the trial court's decision denying Providence's corresponding motion for partial summary judgment. We address only those first two assignments of error.[4] Generally, when reviewing the trial court's decision on cross-motions for summary judgment, "we examine whether there are any disputed issues of material fact and whether either party was entitled to judgment as a matter of law." *Vision Realty, Inc. v. Kohler*, 214 Or App 220, 222, 164 P3d 330 (2007). Where cross-motions for partial summary judgment were made, and a plaintiff assigns error to both the granting of defendant's motion and denial of plaintiff's motion, both motions are subject to review. *Ellis v. Ferrellgas, L. P.*, 211 Or App 648, 652, 156 P3d 136 (2007).

The question before us, as framed by the parties' cross-motions for partial summary judgment, is whether Providence's claim for breach of contract was barred by the reimbursement statutes. We answer that question by applying the familiar methodology of statutory interpretation set out in *PGE v. Bureau of Labor and Industries*, 317 Or 606, 611-12, 859 P2d 1143 (1993), and *State v. Gaines*, 346 Or 160, 171-72, 206 P3d 1042 (2009). We consider the text of the reimbursement statutes in context, as well as the legislative history insofar as it is useful, to discern the intent of the legislature. *Gaines*, 346 Or at 171-72.

We begin with an overview of the reimbursement statutes. The reimbursement statutes, included in ORS chapter 742, explain how an insurer can seek reimbursement of personal injury protection (PIP) benefits or health benefits paid on behalf of its insured who has been injured in an automobile accident through the negligence of another person. *Providence Health Plan v. Winchester*, 252 Or App

[4] In its third assignment of error, Providence challenges the trial court's decision granting defendant's second motion for partial summary judgment. Providence contends that the trial court erred in determining that, because Providence was not entitled to reimbursement from defendant's insurance settlement, it was not authorized under the plan to deny coverage of defendant's additional claims for payment of medical expenses related to the accident. In its fourth assignment of error, Providence challenges the trial court's award of attorney fees to defendant. Both assignments of error are predicated on Providence prevailing on its contention that it was entitled to seek reimbursement from defendant under the plan. Because we reject that contention, as described below, we necessarily reject those assignments of error without further discussion.

283, 290, 288 P3d 13 (2012), *rev den*, 353 Or 562 (2013). Reimbursement may be obtained by one of three mutually exclusive methods: by direct interinsurer reimbursement under ORS 742.534; by placing a lien against the insured's cause of action for damages against the at-fault party under ORS 742.536; or by subrogation under ORS 742.538. *Winchester*, 252 Or App at 291-92. The methods at issue in this case are direct interinsurer reimbursement and subrogation.

Under subrogation, if a PIP insurer or a "health insurer" has paid benefits on an injured persons behalf, the "insurer is entitled to the proceeds of any settlement *** result[ing] from the exercise of any rights of recovery of the injured person against any person legally responsible for the accident." ORS 742.538(1). The PIP insurer or "health insurer" must not have elected recovery by lien under ORS 742.536, and direct interinsurer reimbursement must not be available under ORS 742.534. ORS 742.538; *Winchester*, 252 Or App at 289 ("An insurer may not obtain reimbursement through ORS 742.538 unless 'the interinsurer reimbursement benefit of ORS 742.534 is not available under the terms of that section.'" (Quoting ORS 742.538.)). Further, ORS 742.538(7) provides that any provision in a health insurance policy giving an insurer subrogation rights "shall be construed and applied in accordance with the provisions of [ORS 742.538]."

The interinsurer reimbursement statute, in turn, allows for "reimbursement between insurance companies without any direct involvement on the part of the injured insured." *Winchester*, 252 Or App at 291. If a PIP insurer or an "authorized health insurer" has paid benefits on an injured person's behalf and requests reimbursement, the at-fault party's insurance company must reimburse the PIP insurer or "authorized health insurer." ORS 742.534(1).

We turn to the parties' arguments in this case. Defendant contends that Providence did not properly assert its subrogation rights under ORS 742.538 because, at the time that Providence asserted its subrogation rights, defendant had not yet settled with Nationwide and, therefore,

interinsurer reimbursement remained available under ORS 742.534. Because reimbursement remained available under ORS 742.534, defendant argues, subrogation under ORS 742.538 was not available to Providence. *See Winchester*, 252 Or App at 297-98 (holding that the statute supersedes the subrogation provision in an insurance policy and that the insurer did not comply with the subrogation requirements under ORS 742.538 when it sought subrogation before settlement had occurred, *i.e.*, when interinsurer reimbursement remained available); *State Farm Mutual Automobile Ins. Co. v. Hale*, 215 Or App 19, 29, 168 P3d 285 (2007) (same).

In response, Providence first argues that PEBB is not subject to the reimbursement statutes because it is not an "authorized health insurer" as the term is used in ORS 742.534. Providence asserts that an "authorized" health insurer is any person who holds a certificate of authority to transact health insurance in Oregon. *See* ORS 731.066(1). In Providence's view, PEBB does not hold a certificate of authority, is not required to hold a certificate of authority and, in fact, is not permitted to hold one. ORS 731.390 ("No certificate of authority may be issued to any state, province or foreign government nor to any instrumentality, political subdivision or agency thereof."). Providence contends that, because the legislature determined that PEBB is neither required nor permitted to hold a certificate of authority, the legislature necessarily concluded that PEBB is not an "insurer" and is not "transacting insurance."

Next, Providence argues that PEBB is not subject to the Insurance Code at all, because PEBB is governed by ORS chapter 243 (governing public employee rights and benefits). Providence explains that PEBB is a labor-management board created by statute within the Oregon Health Authority to secure health and other benefits for public employees and their dependents. ORS 243.061; ORS 243.135. PEBB's authority includes contracting with authorized health insurers on behalf of public employees and creating self-insured plans managed by PEBB. ORS 243.105 (1)(a) - (c); ORS 243.145(1). Providence asserts, therefore, that on the face of its enabling statutes, PEBB is not authorized to "transact insurance."

Finally, Providence asserts that, because it is acting only as third-party administrator for PEBB's plan, it is merely acting as PEBB's agent and the reimbursement statutes, which do not apply to PEBB, do not apply to Providence either. Providence explains that, as a "health care service contractor," it is not required to hold a "third-party administrator" license to provide third-party administrator services. *See* ORS 744.702(1) (requiring persons acting as third-party administrators to be licensed); ORS 744.704(1)(e) (exempting from licensing requirement any "insurer that is authorized to transact insurance in this state"); ORS 744.700(3) (defining "insurer" for purposes of the third-party administrator statutes as including health care service contractors). Providence acknowledges that, as a health care service contractor, certain provisions of the Insurance Code, including the reimbursement statutes, are imputed to it. Providence contends, however, that when it acts as a third-party administrator, as in this case, its status as a health care service contractor is irrelevant and the Insurance Code, including the reimbursement statutes, does not apply.

Defendant replies that Providence attempts to evade the statutory requirements of the reimbursement statutes by claiming that it is a third-party administrator when, in truth, Providence is acting as a health care service contractor because it is "intimately connected with a group of doctors [and hospitals] licensed by this state" and provides all the medical benefits to the plan's participants. *See* ORS 750.005(4)(a) (defining "health care service contractor"). Defendant's argument, he asserts, is supported by the agreement between PEBB and Providence, which identifies Providence as a health care service contractor and requires Providence to comply with certain Insurance Code provisions. Further, defendant asserts that, for Providence to be a third-party administrator as it contends that it is, the plan that Providence administers must be "health insurance coverage." *See* ORS 744.702(2) (stating that a person transacts business as a third-party administrator by soliciting or effecting coverage of, underwriting, collecting charges or premiums from, or adjusting or settling claims on residents of Oregon "in connection with life insurance or health insurance coverage"). Accordingly, in

defendant's view, Providence is an insurer administering health insurance.[5]

Whether the reimbursement statutes apply to the plan, to PEBB, or to Providence are not simple questions. If PEBB's plan is an "insurance policy," the reimbursement statutes may apply to it, *see* ORS 742.001 (ORS chapter 742 applies to "all insurance policies delivered or issued for delivery in this state"), despite Providence's contentions that PEBB does not "transact insurance." And, although PEBB may not be an "authorized health insurer" under ORS 742.534 because it does not hold a certificate of authority, PEBB is authorized under ORS 243.145 to self-insure a health benefit plan. Moreover, PEBB is not specifically excluded from the Insurance Code, *see* ORS 731.036 (listing persons and entities exempt from the Insurance Code, including public bodies that self-insure for tort liability and property damage, but not health benefits), and Providence presents no reason why a self-insured entity like PEBB should be excluded from the reimbursement statutes. In any event, we need not decide whether the reimbursement statutes apply to the plan or to PEBB because, for the reasons explained below, we conclude that, in this case, Providence is deemed an insurer and is required to comply with the reimbursement statutes.

As defendant contends, the agreement between PEBB and Providence established that Providence must comply with the reimbursement statutes. As relevant to that argument, Amendment No. 8 to the agreement, effective in 2012, identifies Providence as a health care service contractor and refers to Providence as "Contractor," which is defined in the amendment as "the party providing health benefits and related services to Participants under this

[5] Defendant also argues that PEBB has made itself an insurer, for purposes of the reimbursement statutes, just as Tri-Met made itself an insurer for purposes of the uninsured motorist statutes. *See Haynes*, 337 Or at 665 ("Whether an entity that provides insurance, but is not 'engaged in the business of entering into policies of insurance,' is an 'insurer' for purposes of a particular statute will depend on the meaning of the word 'insurer' in that statute."). Because PEBB is required by statute to "contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees," ORS 243.135(1), defendant argues that PEBB, by electing to self-insure, agreed to provide its members with health insurance and made itself an "insurer" for that purpose.

Agreement" and requires Providence to comply with applicable laws:

> "U. Compliance with Applicable Law.
>
> "[Providence] shall comply with all federal, state, and local laws, regulations, and ordinances applicable to the Agreement. Without limiting the generality of the foregoing, *[Providence] expressly shall comply with the following laws*, regulations and executive orders if applicable to the Agreement:
>
> "(i) If this Agreement is an insurance policy, the Insurance Code as defined in ORS 731.004, or *if [Providence] is a health care service contractor within the meaning of ORS 750.005, the portions of the Insurance Code that ORS 750.055 applies to health care service contractors*."

(Emphases added.) Because Providence is a health care service contractor, defendant argues that, under its contract with PEBB, Providence must comply with ORS 750.055. And defendant explains that ORS 750.055(1) provides that the reimbursement statutes, among other laws, apply to health care service contractors, while ORS 750.055(2) provides that, for the purposes of ORS 750.055, "health care service contractors shall be deemed insurers." Accordingly, defendant asserts that Providence is deemed to be an insurer, the reimbursement statutes apply to Providence, and it is bound under its agreement with PEBB to comply with them.

Providence replies that whether PEBB is subject to the reimbursement statutes does not depend on whether PEBB engaged a third-party administrator that would have been subject to the reimbursement statutes if the third-party administrator owned the claims. According to Providence, nothing in the agreement between PEBB and Providence suggests that PEBB intended to change its relationship to the Insurance Code or to the reimbursement statutes.[6]

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[6] Before the trial court, Providence admitted that the provision in the agreement between PEBB and Providence requiring that Providence, as a health care service contractor, comply with the statutes governing health care service contractors was confusing and needed clarification. Providence argued, however, that the provision applied only if Providence was acting as a health care service contractor under the agreement. Because Providence asserted that it was acting as a third-party administrator under the agreement, Providence argued that the provision did not apply.

Providence misses the point of defendant's argument. Defendant asserts, and we agree, that the agreement between PEBB and Providence identifies Providence as a health care service contractor and requires Providence to comply with the statutes applicable to health care service contractors. Those statutes include the reimbursement statutes. Providence, acting as a health care service contractor under the agreement between PEBB and Providence, is deemed an insurer under ORS 750.055(2). Contrary to Providence's argument, although the agreement between PEBB and Providence does not change PEBB's relationship to the Insurance Code or to the reimbursement statutes, it does require Providence to comply with the statutes applicable to health care service contractors, including the reimbursement statutes, and it made Providence an insurer in this case.

Despite its attempts to cast itself as a third-party administrator, Providence acted as a health care service contractor in its relationship with PEBB. As noted, Providence is exempt from the third-party administrator licensing requirement specifically because it is a health care service contractor. *See* ORS 744.704(1)(e) (insurers authorized to transact insurance are exempt from the third-party administrator licensing requirement); ORS 744.700(3) ("insurer" includes health care service contractors). Although an exemption from the third-party licensing requirements does not mean that Providence could not act as a third-party administrator, it is an indication that Providence's status as a health care service contractor is important, particularly where the importance of Providence's status as a health care service contractor is evident by the agreement between PEBB and Providence.

As expressed in Amendment No. 8 to the agreement, the stated purpose of the PEBB and Providence agreement is for Providence "to provide health benefits for calendar year 2012 to state employees and their dependents." Moreover, as noted above, Providence is identified as "Contractor," which is defined as "the party providing health benefits and related services to Participants." Providing health benefits is more than the administrative tasks that Providence suggests that it performs as a third-party administrator.

The stated purpose of the agreement between PEBB and Providence, as expressed in Amendment No. 8, was that "[Providence] will provide health benefits through its Providence Choice and statewide PPO plans." The fact that the health benefits that Providence was to provide were provided through the already existing plans that Providence offered as a health care service contractor is a strong indication that Providence was more than a third-party administrator. Those existing plans and the health benefits that Providence agreed to provide to PEBB members were possible because of Providence's status as a health care service contractor and its "intimate[] connect[ion] with a group of doctors [and hospitals] licensed by this state." *See* ORS 750.005(4)(a) (defining "health care service contractor"). We conclude that Providence was acting, per the terms of the agreement between PEBB and Providence, as a health care service contractor in its relationship with PEBB.

That conclusion is consistent with our decision in *Winchester*. In that case, Providence argued that, as a health care service contractor, it was exempt from ORS 742.021, which requires that insurance policies contain certain standard provisions. We noted that, as a health care service contractor, Providence was technically a plan to which the defendant subscribed, not an insurer that insured the defendant. *Winchester*, 252 Or App at 285 n 1 (citing ORS 750.005(4)(a)). Nevertheless, for purposes of the statutes at issue in *Winchester*, Providence was deemed an insurer. *Id.* (citing ORS 750.055(1)(e), (2)). Similarly, in this case, because Providence is a health care service contractor and is required by its agreement with PEBB to comply with the statutes governing health care service contractors, including ORS 750.055, Providence is deemed an insurer. Consequently, the reimbursement statutes bar Providence's claim for breach of contract.

Affirmed.